Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution –General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 9-30-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that chiropractic manipulative treatments, manual therapy, manual therapy techniques, telephone call, ROM test, massage, therapeutic activities, office visits, therapeutic exercises, unlisted special procedures, extra spinal manipulation from 10-14-03 through 7-15-04 were not medically necessary. Therefore, the requestor is not entitled to a reimbursement of the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity issues were not the only issues involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 11-02-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

CPT code 98941 on 10-22-03 was denied with an "N". – Spinal manipulation not documented. A review of the medical notes submitted shows that there was no additional documentation to support spinal manipulation. **No reimbursement recommended.**

CPT code 97112 on 10-27-03, 11-3-03, 11-5-03, 11-20-03 and 12-9-03 was denied with a "G". – Unbundling. Per Rule 133.304 (c) Carrier didn't specify which service these were global to, therefore they will be reviewed according to the Medicare Fee Schedule. **Recommend reimbursement of $176.95.**

CPT code 99371 on 10-27-03 was denied with an "M". – No MAR. Per Ingenix Encoder Pro Expert, "Do not pay for telephone calls (codes 99371-99373) because payment for telephone calls is included in payment for billable services (e.g., visit, surgery, diagnostic procedure results). **No further reimbursement recommended.**

CPT code 98940 on 11-3-03 and 11-5-03 were denied with a "G" – Unbundling. Per Rule 133.304 (c) Carrier didn't specify which service this was global to, therefore it will be reviewed according to the Medicare Fee Schedule. **Recommend reimbursement of $63.58. ($31.79 x 2)**

Regarding CPT codes 98940, 97124-59, and 97112 on 11-10-03. Per Rule 133.307 (e)(2)(A), a copy of all medical bills as originally submitted to the carrier for reconsideration in accordance with 133.304 must be submitted to the Commission. **No reimbursement recommended.**

Regarding CPT codes 98940 and 97112 on 11-19-03: Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's, however, reconsideration HCFAs were provided. The disputed service will be reviewed according to the fee guidelines since the

requester submitted "convincing evidence of the carrier's receipt of the provider request for an EOB" according to 133.307 (e)(2)(B). **Recommend reimbursement of $67.18. ($31.79 + $35.39)**

Regarding CPT code 98940 on 11-20-03: Per rules 134.202(a)(4) and 133.304 (c) Carrier didn't specify which service this was global to, therefore it will be reviewed according to the Medicare Fee Schedule. **Reimbursement of $31.79 recommended.**

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c);
plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 10-27-03 through 12-9-03 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 15th day of December 2004.

Donna Auby

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

December 1, 2004

TEXAS WORKERS COMP. COMISSION
AUSTIN, TX 78744-1609

CLAIMANT:
EMPLOYEE:
POLICY: M5-05-0395-01 IRO Certificate: #5278
TWCC:

Medical Review Institute of America (MRIoA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Workers Compensation Commission has assigned the above mentioned case to MRIoA for independent review in accordance with TWCC Rule 133 which provides for medical dispute resolution by an IRO.

MRIoA

MRIoA has performed an independent review of the case in question to determine if the adverse determination was appropriate. In performing this review all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the TWCC approved doctor list (ADL). The reviewer has signed a statement indicating they have no known conflicts of interest existing between themselves and the treating doctors/providers for the patient in question or any of the doctors/providers who reviewed the case prior to the referral to MRIoA for independent review.

Records Received:

Records Received from TWCC:

Notification of IRO assignment dated 11/1/04, 1 page
Letter from Texas Workers' Compensation Commission dated 10/29/04, 1 page
Medical dispute resolution request/response form dated 9/30/04, 2 pages
Table of disputed services for dates 10/14/03 through 7/15/04, 13 pages
Explanation of medical benefits forms dated 10/14/03 through, 106 pages

Records Received from Dr. Steve Minors:

Office reports from Dr. Minors dated 9/16/04 and 11/16/04, 9 pages
Annotated bibliography dated 2004, 9 pages
Letter from Dr. Minors' office dated 11/8/04, 1 page
Letter from Texas Workers' Compensation Commission dated 11/2/04, 1 page
Fax coversheet from Dr. Minors' office dated 11/8/04, 1 page
Facsimile cover sheet from MRIoA dated 11/4/04, 1 page
Retrospective review (M5) information request from MRIoA dated 11/4/04, 1 page
Letter from Texas Workers' Compensation Commission dated 10/29/04, 1 page
MDR cover letter dated 9/30/04, 2 pages
Medical dispute resolution request/response, undated, 3 pages
Table of disputed services for dates 10/14/03 through 7/15/04, 13 pages
HCFA-1500 forms for dates of service 10/14/03 through 7/15/04, 71 pages
Patient office visit reports dated 10/14/03 through 7/15/04, 77 pages
Explanation of medical benefits forms dated 10/14/03 through 7/15/04, 191 pages
Letter from Dr. Minors dated 10/27/03, 1 page
Physician review of patient's diagnostic exam dated 2/27/04, 3 pages
Compliance and practice administrative violation letter dated 9/29/04, 1 page
Delivery log dated 8/20/04, 1 page
Letter from Dr. Minors' office dated 8/19/03, 2 pages
Fax coversheet from Dr. Minors' office dated 9/29/04, 1 page

MRIoA

Summary of Treatment/Case History:
The patient underwent physical medicine treatments and surgery after sustaining an injury at work on ___ while attempting to restrain a youth.

Questions for Review:
The dates of service in question are 10/14/03 through 7/15/04. Please advise medical necessity of the following services: #98941 (chiropractic manipulation treatment spinal 3-4 regions), #97140 (manual therapy technique mobile manipulation), #97112 (therapeutic procedure neuromuscular re-education), #98940 (chiropractic manipulation treatment spinal 1-2 regions), #99371 (telephone call by physician to patient or for medical management), #95851 (range of motion), #97124 (therapeutic procedure massage), #97530 (therapeutic activities one on one patient and provider), #99213 (office visit), #99211 (office visit), #97110 (therapeutic procedure range of motion), #99199 (unlisted special service procedure or report), and #98943 (chiropractic manipulation treatment extra spinal one or more regions).

Explanation of Findings:
The following codes #98941 (chiropractic manipulative treatments), #97112 (manual therapy), #97140 (manual therapy techniques), #98940 (chiropractic manipulative treatments), #99371 (telephone call), #95851 (range of motion), #97124 (massage), #97530 (therapeutic activities), #99213 (office visits), #97110 (therapeutic exercises), #99199 (unlisted special procedure), #98943 (extra spinal manipulation) from 10/14/03 through 7/15/04 are not medically necessary to treat this patient's condition.

Rationale: After reviewing the provider's medical records and the carrier's EOBs for the disputed treatments for the dates in question, I completely concur with the carrier's position and the reimbursement amounts that were made.

The carrier was absolutely correct in its denial of the two manipulative codes, since according to CPT (reference 1), it would be duplicative to bill #98941 along with #98940 on the same visit.

While the provider's "Annotated Bibliography 2004" listed many studies on a variety of topics, very few had any relevancy to this claimant, her conditions and her treatments. In regard to the one-on-one therapy in dispute, the current medical literature states, "…there is no strong evidence for the effectiveness of supervised training as compared to home exercises" (reference 2).

The *Guidelines for Chiropractic Quality Assurance and Practice Parameters* (reference 3) chapter 8 under "Failure to Meet Treatment/Care Objectives" states, "After a maximum of two trial therapy series of manual procedures lasting up to two weeks each (four weeks total) without significant documented improvement, manual procedures may no longer be appropriate and alternative care should be considered." The ACOEM Guidelines (reference 4) state that if manipulation does not bring improvement in three to four weeks, it should be stopped and the patient reevaluated. In this case, there was no material improvement in the patient's condition, and thus no documentation to support the medical necessity of continuing the treatment.

In general, most computerized documentation, regardless of the software used, fails to provide individualized information necessary for reimbursement. The Center for Medicare and Medicaid Services (CMS) has stated, "Documentation should detail the specific elements of the chiropractic service for this particular patient on this day of service. It should be clear from the documentation why the service was necessary that day. Services supported by repetitive entries lacking encounter specific information will be denied." In this case, there is insufficient documentation to support the medical necessity for the treatment in question, since the computer-generated daily progress notes were nearly identical on most dates of service. The issue of exercise logs is a prime example of the shortcomings of computerized notes. Although the provider stated, "There is no rule; law or statute that states this be done," CPT (reference 1) time-based codes must be documented and plugging in "30 minutes" or "15 minutes" does not satisfy the "encounter specific information" requirement.

The records also failed to substantiate that the disputed services fulfilled statutory requirements (reference 5), since the patient obtained no significant relief, promotion of recovery was not accomplished, and there is no indication that the treatment had any effect on the employee's ability to retain employment.

The TWCC Medical Fee Guideline (reference 6) identifies the criteria that must be met for physical medicine treatment to qualify for reimbursement: (1) the patient's condition shall have the potential for restoration of function and (2) the treatment shall be specific to the injury and provide for the potential improvement of the patient's condition. Potential for restoration of function is identified by progressive return to function. Without demonstration of objective progress, ongoing treatment cannot be reasonably expected to restore this patient's function and thus can only be deemed medically unnecessary. According to the Medicare Guidelines, if a patient's expected restoration potential is insignificant in relation to the extent and duration of the physical medicine services required to achieve such potential, the services are not considered reasonable or necessary. In this case, it was entirely foreseeable that surgery would be required and that the continuing treatments would offer little or no benefit. In fact, the provider stated this in his 6/1/04 note, "It has been my opinion that the pt would benefit from surgical intervention and that treatment here was not to cure/fix the problem."

Conclusion/Decision to Not Certify:

The following codes #98941 (chiropractic manipulative treatments), #97112 (manual therapy), #97140 (manual therapy techniques), #98940 (chiropractic manipulative treatments), #99371 (telephone call), #95851 (range of motion), #97124 (massage), #97530 (therapeutic activities), #99213 (office visits), #97110 (therapeutic exercises), #99199 (unlisted special procedure), #98943 (extra spinal manipulation) from 10/14/03 through 7/15/04 are not medically necessary to treat this patient's condition.

References Used in Support of Decision:

1. CPT 2004: Physician's Current Procedural Terminology, Fourth Edition, Revised. (American Medical Association, Chicago, IL 1999)

2. Ostelo RW, de Vet HC, Waddell G, Kerchhoffs MR, Leffers P, van Tulder M, Rehabilitation following first-time lumbar disc surgery: a systematic review within the framework of the cochrane collaboration. Spine. 2003 Feb 1;28(3):209-18.
3. Haldeman, S; Chapman-Smith, D; Petersen, D Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen Publishers, Inc.
4. ACOEM Occupational Medicine Practice Guidelines: Evaluation and Management of Common Health Problems and Functional Recovery in Workers, 2nd Edition, p. 299.
5. Texas Labor Code 408.021
6. 1996 TWCC Medical Fee Guideline, Medicine Ground Rules, Section I, A, p. 31.

This review was provided by a chiropractor who is licensed in Texas, certified by the National Board of Chiropractic Examiners, is a member of the American Chiropractic Association and has several years of licensing board experience. This reviewer has written numerous publications and given several presentations with their field of specialty. This reviewer has been in continuous active practice for over twenty-five years.

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